February 2017

New Vision Plan Changes Effective Jan.1, 2017

Effective Jan. 1, 2017, Blue Cross and Blue Shield of Illinois (BCBSIL) members transitioned from Davis Vision to EyeMed. This impacts all HMO members including, HMO Illinois®, Blue Advantage HMOSM, Blue Precision HMOSM and BlueCare DirectSM, and Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM members.

In November 2016, BCBSIL sent letters to affected members notifying them of the new vision vendor. With EyeMed, the member also receives discounts on eyewear materials in addition to the funded benefit. If you have any questions regarding this transition, please contact your BCBSIL Provider Network Consultant.

For all other BCBSIL members, providers for vision care could vary. Contact the Customer Service number on the member’s ID card to verify vision benefits.

EyeMed Vision Care is an independent company that administers the vision benefits for BCBSIL.

bcbsil.com/provider

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Fax Number Correction for Government Programs Claims

In our December 2016 Blue Review, we published an article titled, Government Programs Claims Handling and Post-adjudication Process Changes, Effective Jan. 1, 2017. This article included an overview of changes related to claims submitted for Blue Cross Medicare AdvantageSM and Blue Cross Community OptionsSM, or Blue Cross and Blue Shield of Illinois (BCBSIL) Medicaid, members. Please note that the new fax numbers for paper claims referenced in this article were incorrect and should not be used. Government programs claims may not be submitted via fax. The new mailing addresses for paper claims included in the article were correct.

ELECTRONIC CLAIM SUBMISSION REMINDERS

BCBSIL encourages electronic claim submission to help expedite processing. It is important to use the correct Payer ID on your electronic claims to help ensure proper routing of these claims.

- The Payer ID for electronic Blue Cross Medicare Advantage claims is 66006. If you use a vendor other than AvailityTM or Passport/Experian for electronic claim submission, contact your vendor to confirm they are using Payer ID 66006, rather than assigning their own unique number.
- The Payer ID for BCBSIL Medicaid claims is MCDIL for Availity and Passport/Experian users. If you use a vendor other than Availity or Passport/Experian, contact your vendor for the correct Payer ID to use on electronic claims submitted for BCBSIL Medicaid members.

Refer to the Related Resources on the Medicare/Medicaid page in the Network Participation section of our website at bcbsil.com/provider to view an updated version of the article referenced above. If you have questions or need assistance, contact your BCBSIL Provider Network Consultant.

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February 2017

Fairness in Contracting

In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, Blue Cross and Blue Shield of Illinois (BCBSIL) has designated a column in the *Blue Review* to notify you of any significant changes to the physician fee schedules. Be sure to review this area each month.

Effective Feb. 1, 2017, code ranges A0225-A0434 were updated. Please note that not all codes in this range were affected.

Effective March 1, 2017, select immunizations, vaccines and toxoids in the 90281-90396 and 90476-90748 Current Procedural Terminology (CPT®) code ranges will be updated. Please note that not all CPT codes in this range will be affected.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates can also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above can also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the *Blue Review*. The form is available on the [Forms page](http://bcbsil.com/provider) in the Education and Reference Center on our website at [bcbsil.com/provider](http://bcbsil.com/provider).

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**Effective March 8, 2017: Medicare Outpatient Observation Notice (MOON) Required**

Effective March 8, 2017, the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act requires hospitals and Critical Access Hospitals (CAHs) to provide the MOON to Medicare beneficiaries, including Blue Cross Medicare Advantage (PPO)℠, Blue Cross Medicare Advantage (HMO)℠ and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ members receiving observation services as outpatients for more than 24 hours. The MOON explains the status of the individual as an outpatient as opposed to an inpatient, along with the implications of observation services on cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services.

An oral explanation of the MOON must be provided, ideally in conjunction with the delivery of the notice, no later than 36 hours after observation services are initiated or, if sooner, upon release. In addition, a signature must be obtained from the individual, or an individual qualified to act on their behalf, to acknowledge receipt and understanding of the notice. In cases where the individual or person refuses to sign the MOON, the staff member of the hospital or CAH providing the notice must sign the notice to certify that notification was presented.

The MOON and instructions can be found at [cms.gov/bni/](https://www.cms.gov/bni/) or [cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-08-3.html](https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-12-08-3.html).

The information provided here is only intended to be a brief summary of the law that have been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here you should consult with your legal advisor.
ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to or deleted from the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. Blue Cross and Blue Shield of Illinois (BCBSIL) will normally load this additional data to the BCBSIL claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSIL Provider website. Advance notification of updates to the ClaimsXten software version (i.e., change from ClaimsXten version 4.1 to 4.4) also will be posted on the BCBSIL Provider website.

To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSIL's code-auditing software. Refer to the Clear Claim Connection page in the Education and Reference Center/Provider Tools section of our Provider website for additional information on gaining access to C3, as well as answers to frequently asked questions about ClaimsXten. Updates may be included in future issues of the Blue Review.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third party vendor that is solely responsible for its products and services.
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Check Eligibility and Benefits Before Assuming You’re In- or Out-of-Network

It is extremely important to check eligibility and benefits prior to rendering services or assuming that you or your practice/medical group are out-of-network for a particular member. Conducting this step will help you identify the member’s product/plan, the network(s) they may use, benefit preauthorization requirements, and other important details.

Checking eligibility and benefits electronically through Availity™, or your preferred vendor portal, is strongly encouraged. Electronic eligibility and benefits inquiries may be conducted for local Blue Cross and Blue Shield of Illinois (BCBSIL) members, as well as out-of-area Blue Plan and Federal Employee Program (FEP) members.

For additional information, such as a library of online transaction tip sheets organized by specialty, refer to the Eligibility and Benefits page in the Claims and Eligibility section of our website at bcbsil.com/provider. BCBSIL also offers educational webinars with an emphasis on electronic transactions, including eligibility and benefits. We invite you to join us for a BCBSIL Back to Basics: ‘Availity 101’ Webinar – visit the Webinars page in the Education and Reference Center section of our Provider website for dates and times of upcoming sessions.

Verification of eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility, any claims received during the interim period and the terms of the member’s certificate of coverage applicable on the date services were rendered.

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Blue Cross Medicare Advantage™: Claim Rejections for Taxonomy Code

Taxonomy codes are not required on claims submitted for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM members. However, due to a recent system issue, electronic Blue Cross Medicare Advantage claims submitted with Payer ID 66006 Jan. 1, 2017, through Jan. 11, 2017, may have been rejected for a missing provider taxonomy code.

The following error message was returned for those affected claims: “The provider information segment (loop 2000A, PRV) must be submitted because the provider’s taxonomy code impacts adjudication.”

The system issue causing the rejected claims was resolved as of Jan. 11, 2017. Providers who were impacted by this issue must resubmit the rejected claims for processing and adjudication.

As a reminder, the preferred method for claim submission is electronically. Government programs claims may not be submitted via fax.

We appreciate your patience and apologize for any inconvenience that this issue may have caused your practice.
BCBSIL Medicaid: Error Response on Electronic Inquiries

When conducting electronic eligibility and benefits (270) and claim status (276) transactions for Blue Cross and Blue Shield of Illinois (BCBSIL) Medicaid members using Availity™ or your preferred vendor portal, the correct payer option to select is “Blue Cross Community OptionsSM.” This applies to the following BCBSIL Medicaid members:

- Blue Cross Community MMAI (Medicare-Medicaid Plan)SM
- Blue Cross Community Integrated Care Plan (ICP)SM
- Blue Cross Community Family Health PlanSM (FHP)
- Blue Cross Community Managed Long Term Supports and ServicesSM (MLTSS)

As noted above, Blue Cross Community Options is the correct payer option for online eligibility and benefits/claim status inquiries for MMAI, ICP, FHP and MLTSS members. However, due to a system issue, providers conducting these inquiries through the Availity Web portal between January 1 and 15 of this year may have received the following error message: “Authorization/Access Restrictions – Please Correct and Resubmit.”

The system issue producing the Authorization/Access Restrictions error response was resolved as of Jan. 16, 2017. Impacted providers may resume submitting electronic 270 and 276 inquiries through Availity for BCBSIL Medicaid members effective immediately. We appreciate your patience and apologize for any inconvenience that this issue may have caused your practice.

Checking eligibility and/or benefit information is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s certificate of coverage applicable on the date services were rendered. If you have any questions, please call the number on the member’s ID card.

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Availity™ Claim Research Tool Offers Enhanced Status Results

One of the most convenient, efficient and secure methods of requesting detailed claim status information from Blue Cross and Blue Shield of Illinois (BCBSIL) is by using an online option such as the Availity Claim Research Tool (CRT). This online tool now returns more detailed information than ever before.

The CRT allows registered Availity users to search for claims by Member ID, Group Number and Date of Service, or by National Provider Identifier (NPI) and specific claim number, also known as a Document Control Number (DCN). The CRT enables users to check the status of multiple claims in one view to obtain near real-time claim status, with easy-to-read denial descriptions.

The CRT search results page now delivers the rendering provider ID and name submitted on the claim. Additionally, the claim status service line break-down returns:

- Diagnosis Code
- Copay
- Coinsurance
- Deductible
- Modifier
- Unit or Time or Mile

This important information is available within a few clicks, lessening the need to speak with a Customer Advocate. For additional information, refer to the CRT tip sheet in the Education and Reference Center/Provider Tools section of our website at bcbsil.com/provider. As a reminder, you must be registered with Availity to utilize the CRT. For registration information, visit availity.com, or contact Availity Client Services at 800-282-4548.

Join us for a webinar! Blue Cross and Blue Shield of Illinois (BCBSIL) hosts complimentary Back to Basics: ‘Availity 101’ Webinars for providers to learn how to use the CRT and other electronic tools to the fullest potential. You do not need to be an existing Availity user to attend a webinar. To register online now for an upcoming webinar, visit the Webinars page in the Education and Reference Center section of our Provider website.

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**Annual Medical Record Data Collection for Quality Reporting Begins Feb. 1, 2017**

Blue Cross and Blue Shield of Illinois (BCBSIL) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®), and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS®). HEDIS is one of the most widely used and nationally accepted effectiveness of care measurements available and HHS requires reporting of QRS measures.

The collection of the above-referenced performance data is considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, and patient authorization for release of information is not required. To meet HEDIS and QRS reporting requirements, BCBSIL will be collecting medical records using internal resources and leveraging the independently contracted third party vendor from last year, CIOX Health (formerly ECS).

If you receive a request for medical records, we encourage you to reply within 7 to 10 business days. BCBSIL, or the vendor referenced above, may be contacting your office or facility in February or March 2017 to identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email or onsite visit).

Appointments for onsite visits will be scheduled with your staff, if applicable. You will then receive a letter outlining the information that is being requested, along with the medical record request list with members’ names and the identified measures that will be reviewed. If you have any questions about medical record requests, please contact the BCBSIL Quality Improvement (HEDIS) Department at 312-653-5005.

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February 2017

Provider Learning Opportunities

emphasis on electronic options that can help create administrative efficiencies for the independently contracted providers who conduct business with us. A snapshot of upcoming training sessions is included below. To register online now, visit the Webinars page in the Education and Reference Center on our website at bcbsil.com/provider.

<table>
<thead>
<tr>
<th>BCBSIL WEBINARS</th>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td><strong>BCBSIL Back to Basics: ‘Availity™ 101’</strong></td>
<td>Feb. 7, 2017</td>
<td>11 a.m. to noon</td>
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<td>A review of electronic transactions, provider tools and online resources.</td>
<td>Feb. 14, 2017</td>
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<td></td>
<td>Feb. 21, 2017</td>
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<td>Feb. 28, 2017</td>
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<tr>
<td><strong>Availity Reporting On-Demand</strong></td>
<td>Feb. 8, 2017</td>
<td>2 to 3 p.m.</td>
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<td>This new tool permits registered Availity users to readily view, download, save and/or print the Provider Claim Summary online.</td>
<td>Feb. 15, 2017</td>
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<td>Feb. 22, 2017</td>
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<td></td>
<td>March 1, 2017</td>
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<tr>
<td><strong>iExchange® Training: New Enrollee Training</strong></td>
<td>Feb. 14, 2017</td>
<td>11 a.m. to 12:15 p.m.</td>
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<td>Learn how to gain access to and begin using our online benefit preauthorization/predetermination of benefits tool.</td>
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<tr>
<td><strong>Introducing Remittance Viewer</strong></td>
<td>Feb. 21, 2017</td>
<td>10 to 11 a.m.</td>
</tr>
<tr>
<td>This online tool offers providers and billing services a convenient way to retrieve, view, save or print claim detail information.</td>
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